

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
\$M 2/57

Item 20 Film 246 8-4-59 ans
8052
STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08023

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> c. LENGTH OF STAY IN 1b <u>6 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Batchelor</u> First <u>Herbert</u> Middle <u>Elbourn</u> Last <u>Batchelor</u>		4. DATE OF DEATH <u>July</u> Month <u>23</u> Day <u>1959</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-5-52</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>6</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>William Batchelor</u>		14. MOTHER'S MAIDEN NAME <u>Helen Elbourn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>mother</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> <u>850x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>850x</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>The child was playing in a row boat with companion. He reached overboard and fell into the water.</u>	
20c. TIME OF INJURY Month, Day, Year <u>7/23/59</u> Hour <u>9</u> a.m. <u>7:15</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Chesapeake Bay</u>	20f. (City or town) <u>Rock Hall</u> (County) <u>Kent</u> (State) <u>Maryland</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William N. Laterra</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <u>7/23/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	22d. LOCATION (City, town, or county) <u>Rock Hall</u> (State) <u>md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L Lane</u> ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

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FOR STATE
HEALTH DEPT.

1

Robert Jare
Chattanooga

STATE OF TENNESSEE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2022

DECEASED

NAME

AGE

SEX

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DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF EXAMINATION

PLACE OF EXAMINATION

EXAMINER'S SIGNATURE

DATE OF SIGNATURE

PLACE OF SIGNATURE

EXAMINER'S TITLE

DATE OF TITLE

PLACE OF TITLE

EXAMINER'S ADDRESS

DATE OF ADDRESS

PLACE OF ADDRESS

EXAMINER'S PHONE

DATE OF PHONE

PLACE OF PHONE

EXAMINER'S FAX

DATE OF FAX

PLACE OF FAX

EXAMINER'S E-MAIL

DATE OF E-MAIL

PLACE OF E-MAIL

EXAMINER'S WEBSITE

DATE OF WEBSITE

PLACE OF WEBSITE

EXAMINER'S SOCIAL MEDIA

DATE OF SOCIAL MEDIA

PLACE OF SOCIAL MEDIA

EXAMINER'S OTHER CONTACT

DATE OF OTHER CONTACT

PLACE OF OTHER CONTACT

EXAMINER'S SIGNATURE

DATE OF SIGNATURE

PLACE OF SIGNATURE

EXAMINER'S TITLE

DATE OF TITLE

PLACE OF TITLE

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8053 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08024

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton Rural		c. LENGTH OF STAY IN 1b 23 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Besse Last 4. DATE OF DEATH Month July Day 22 Year 19 59							
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1879		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MICHAEL Coughran				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT Willis Wells, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arterio sclerotic cardio vascular disease (a), stating the underlying cause last. DUE TO several years (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the Bladder - operation August 1958						INTERVAL BETWEEN ONSET AND DEATH Short	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Robert W. Farr				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Robert W. Farr, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-25-59		22c. NAME OF CEMETERY OR CREMATORY STILL POND CEMTY		22d. LOCATION (City, town, or county) (State) STILL POND, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Victor M. Kennedy				ADDRESS STILL POND, MD.		24a. REC'D BY REGISTRAR DATE JUL 24 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

DATE SIGNED
7/22/59

FOR STATE
HEALTH DEPT.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8040

CERTIFICATE OF DEATH

Reg. Dist. No.

08025

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Q. A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp.				d. STREET ADDRESS Chester Motel			
3. NAME OF DECEASED (Type or print) First Middle Last EMORY MILLER BONWILL				4. DATE OF DEATH Month Day Year July 30 / 59 19			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25 1895	9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Motel		11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. H. Bonwill				14. MOTHER'S MAIDEN NAME Florence May Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-14-0891		17. INFORMANT Address Mrs. Adel B. Bonwill Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Kidney failure 916.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Extensive thermal burns DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days 7 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) With motor running pt. filled tank from open gasoline can-fire and explosion.			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 1:30 p. m. July 23 1959				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/> Farm		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Near Chestertown Q.A. Md.	
20f. (City or town) (State) (Country)				20g. (City or town) (State) (Country)			
21. I certify that I attended the deceased from 7-23 , 19 59 , to 7-30 , 19 59 , that I last saw the deceased alive on 7-30 , 19 59 , and that death occurred at 5:45 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Maryland DATE SIGNED 7-31-59							
ACTUAL SIGNATURE A.C. Dick				PHYSICIAN'S NAME (Type) A.C. Dick			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 1 / 59		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams				24a. REC'D BY REGISTRAR DATE AUG 5 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2040

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF DEATH [REDACTED]</p>		<p>5. TIME OF DEATH [REDACTED]</p>		<p>6. PLACE OF DEATH [REDACTED]</p>	
<p>7. CAUSE OF DEATH [REDACTED]</p>		<p>8. MANNER OF DEATH [REDACTED]</p>		<p>9. MEDICAL HISTORY [REDACTED]</p>	
<p>10. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>11. SIGNATURE OF DECEASED [REDACTED]</p>		<p>12. SIGNATURE OF WITNESSES [REDACTED]</p>	
<p>13. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>14. SIGNATURE OF CLERK [REDACTED]</p>		<p>15. SIGNATURE OF JURY [REDACTED]</p>	
<p>16. SIGNATURE OF JURY [REDACTED]</p>		<p>17. SIGNATURE OF JURY [REDACTED]</p>		<p>18. SIGNATURE OF JURY [REDACTED]</p>	
<p>19. SIGNATURE OF JURY [REDACTED]</p>		<p>20. SIGNATURE OF JURY [REDACTED]</p>		<p>21. SIGNATURE OF JURY [REDACTED]</p>	
<p>22. SIGNATURE OF JURY [REDACTED]</p>		<p>23. SIGNATURE OF JURY [REDACTED]</p>		<p>24. SIGNATURE OF JURY [REDACTED]</p>	
<p>25. SIGNATURE OF JURY [REDACTED]</p>		<p>26. SIGNATURE OF JURY [REDACTED]</p>		<p>27. SIGNATURE OF JURY [REDACTED]</p>	
<p>28. SIGNATURE OF JURY [REDACTED]</p>		<p>29. SIGNATURE OF JURY [REDACTED]</p>		<p>30. SIGNATURE OF JURY [REDACTED]</p>	
<p>31. SIGNATURE OF JURY [REDACTED]</p>		<p>32. SIGNATURE OF JURY [REDACTED]</p>		<p>33. SIGNATURE OF JURY [REDACTED]</p>	
<p>34. SIGNATURE OF JURY [REDACTED]</p>		<p>35. SIGNATURE OF JURY [REDACTED]</p>		<p>36. SIGNATURE OF JURY [REDACTED]</p>	
<p>37. SIGNATURE OF JURY [REDACTED]</p>		<p>38. SIGNATURE OF JURY [REDACTED]</p>		<p>39. SIGNATURE OF JURY [REDACTED]</p>	
<p>40. SIGNATURE OF JURY [REDACTED]</p>		<p>41. SIGNATURE OF JURY [REDACTED]</p>		<p>42. SIGNATURE OF JURY [REDACTED]</p>	
<p>43. SIGNATURE OF JURY [REDACTED]</p>		<p>44. SIGNATURE OF JURY [REDACTED]</p>		<p>45. SIGNATURE OF JURY [REDACTED]</p>	
<p>46. SIGNATURE OF JURY [REDACTED]</p>		<p>47. SIGNATURE OF JURY [REDACTED]</p>		<p>48. SIGNATURE OF JURY [REDACTED]</p>	
<p>49. SIGNATURE OF JURY [REDACTED]</p>		<p>50. SIGNATURE OF JURY [REDACTED]</p>		<p>51. SIGNATURE OF JURY [REDACTED]</p>	
<p>52. SIGNATURE OF JURY [REDACTED]</p>		<p>53. SIGNATURE OF JURY [REDACTED]</p>		<p>54. SIGNATURE OF JURY [REDACTED]</p>	
<p>55. SIGNATURE OF JURY [REDACTED]</p>		<p>56. SIGNATURE OF JURY [REDACTED]</p>		<p>57. SIGNATURE OF JURY [REDACTED]</p>	
<p>58. SIGNATURE OF JURY [REDACTED]</p>		<p>59. SIGNATURE OF JURY [REDACTED]</p>		<p>60. SIGNATURE OF JURY [REDACTED]</p>	
<p>61. SIGNATURE OF JURY [REDACTED]</p>		<p>62. SIGNATURE OF JURY [REDACTED]</p>		<p>63. SIGNATURE OF JURY [REDACTED]</p>	
<p>64. SIGNATURE OF JURY [REDACTED]</p>		<p>65. SIGNATURE OF JURY [REDACTED]</p>		<p>66. SIGNATURE OF JURY [REDACTED]</p>	
<p>67. SIGNATURE OF JURY [REDACTED]</p>		<p>68. SIGNATURE OF JURY [REDACTED]</p>		<p>69. SIGNATURE OF JURY [REDACTED]</p>	
<p>70. SIGNATURE OF JURY [REDACTED]</p>		<p>71. SIGNATURE OF JURY [REDACTED]</p>		<p>72. SIGNATURE OF JURY [REDACTED]</p>	
<p>73. SIGNATURE OF JURY [REDACTED]</p>		<p>74. SIGNATURE OF JURY [REDACTED]</p>		<p>75. SIGNATURE OF JURY [REDACTED]</p>	
<p>76. SIGNATURE OF JURY [REDACTED]</p>		<p>77. SIGNATURE OF JURY [REDACTED]</p>		<p>78. SIGNATURE OF JURY [REDACTED]</p>	
<p>79. SIGNATURE OF JURY [REDACTED]</p>		<p>80. SIGNATURE OF JURY [REDACTED]</p>		<p>81. SIGNATURE OF JURY [REDACTED]</p>	
<p>82. SIGNATURE OF JURY [REDACTED]</p>		<p>83. SIGNATURE OF JURY [REDACTED]</p>		<p>84. SIGNATURE OF JURY [REDACTED]</p>	
<p>85. SIGNATURE OF JURY [REDACTED]</p>		<p>86. SIGNATURE OF JURY [REDACTED]</p>		<p>87. SIGNATURE OF JURY [REDACTED]</p>	
<p>88. SIGNATURE OF JURY [REDACTED]</p>		<p>89. SIGNATURE OF JURY [REDACTED]</p>		<p>90. SIGNATURE OF JURY [REDACTED]</p>	
<p>91. SIGNATURE OF JURY [REDACTED]</p>		<p>92. SIGNATURE OF JURY [REDACTED]</p>		<p>93. SIGNATURE OF JURY [REDACTED]</p>	
<p>94. SIGNATURE OF JURY [REDACTED]</p>		<p>95. SIGNATURE OF JURY [REDACTED]</p>		<p>96. SIGNATURE OF JURY [REDACTED]</p>	
<p>97. SIGNATURE OF JURY [REDACTED]</p>		<p>98. SIGNATURE OF JURY [REDACTED]</p>		<p>99. SIGNATURE OF JURY [REDACTED]</p>	
<p>100. SIGNATURE OF JURY [REDACTED]</p>		<p>101. SIGNATURE OF JURY [REDACTED]</p>		<p>102. SIGNATURE OF JURY [REDACTED]</p>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8041

CERTIFICATE OF DEATH

08026

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Thomas R. Brockson		4. DATE OF DEATH Month July Day 6 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1888
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Brockson		14. MOTHER'S MAIDEN NAME Minnie Mier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-30-0952A	
17. INFORMANT Thomas R. Brockson Jr.		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Coronary arterio sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH very short 4 or 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chestertown Kent, Md.
21. I certify that I attended the deceased from 6/12 , 19 59 , to 7/6 , 19 59 , that I last saw the deceased alive on 7/6 , 19 59 , and that death occurred at 10 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Maryland DATE SIGNED			
ACTUAL SIGNATURE Robert W. Farr		M.D. Robert W. Farr, M.D.	
PHYSICIAN'S NAME (Type) Robert W. Farr, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 9, 1959	22c. NAME OF CEMETERY OR CREMATORY Georgetown Cemetery	22d. LOCATION (City, town, or county) (State) Georgetown, Kent Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward L. Hous. Millington, Md.		24a. REC'D BY REGISTRAR DATE JUL 9 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hous.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 or 5 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8054 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08027

1. PLACE OF DEATH o. COUNTY Kent M X		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coleman's Corner		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at Home (RFD Worton)		/d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alonza Brooks		4. DATE OF DEATH Month July 19, 1959 Day 19 Year	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 20, 1908
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY various	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Brooks		14. MOTHER'S MAIDEN NAME Alice Piner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-12-3759	
17. INFORMANT Bertrude Brooks - Worton, Md. RFD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probably Coronary Thrombosis 420.1 DUE TO Arteriosclerotic Cardiovascular disease Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Deceased suffered from heart trouble for some time. He was last seen by a physician 3 or 4 months ago. In a state of health not significantly different from the usual, last night, he was found dead in bed at about 8:30 A.M. today.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 7/19/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 22, 1959	
22c. NAME OF CEMETERY OR CREMATORY Coleman's Cem.		22d. LOCATION (City, town, or county) (State) near - Worton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE Jul 21 '59		24b. REGISTRAR'S SIGNATURE - J. S. Hines	

MEDICAL CERTIFICATION

STATE OF NEW YORK
DEPARTMENT OF HEALTH

RECEIVED
JAN 10 1964
NEW YORK

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]	
2. SEX [REDACTED]	
3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]	
5. PLACE OF DEATH [REDACTED]	
6. OCCASION OF DEATH [REDACTED]	
7. CAUSE OF DEATH [REDACTED]	
8. MANNER OF DEATH [REDACTED]	
9. SIGNATURE OF MEDICAL EXAMINER [REDACTED]	
10. SIGNATURE OF REGISTRAR [REDACTED]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8055

CERTIFICATE OF DEATH

Reg. Dist. No.

08028

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ARTHUR Last BROOKS		4. DATE OF DEATH Month July Day 9 Year 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 25, 1881
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Millington, Md.
13. FATHER'S NAME Henry Brooks		14. MOTHER'S MAIDEN NAME Martha Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-16-5432	17. INFORMANT Paul Duckery, Address Millington, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) Pyelonephritis			INTERVAL BETWEEN ONSET AND DEATH 11 days years 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 29, 1959 to July 9, 1959 , that I last saw the deceased alive on July 8, 1959 , and that death occurred at 6 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Geza Koralewski		ADDRESS (Street, city or town, state) MILLINGTON, MD	
PHYSICIAN'S NAME (Type) GEZA KORALEWSKI		DATE SIGNED 7.9.59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 12, 1959	22c. NAME OF CEMETERY OR CREMATORY Millington Colored Cemetery	22d. LOCATION (City, town, or county) (State) Millington, Kent Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellous		ADDRESS Millington, Md.	
24a. REC'D BY REGISTRAR JUL 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

2025

100-100000

NAME OF DECEASED M. J. JONES		AGE 45		SEX Male		RACE White		DATE OF BIRTH 10-15-1910		PLACE OF BIRTH Baltimore, Md.	
DATE OF DEATH 10-25-1960		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE NO. 100-100000	
FATHER'S NAME J. J. Jones		MOTHER'S NAME M. J. Jones		FATHER'S OCCUPATION None		MOTHER'S OCCUPATION None		FATHER'S PLACE OF BIRTH Baltimore, Md.		MOTHER'S PLACE OF BIRTH Baltimore, Md.	
DECEASED'S OCCUPATION None		DECEASED'S PLACE OF BIRTH Baltimore, Md.		DECEASED'S DATE OF BIRTH 10-15-1910		DECEASED'S SEX Male		DECEASED'S RACE White		DECEASED'S AGE 45	
DECEASED'S MANNER OF DEATH Natural		DECEASED'S CAUSE OF DEATH Heart Disease		DECEASED'S PLACE OF DEATH Home		DECEASED'S TIME OF DEATH 10:00 AM		DECEASED'S DATE OF DEATH 10-25-1960		DECEASED'S NAME M. J. JONES	
DECEASED'S FATHER'S NAME J. J. Jones		DECEASED'S MOTHER'S NAME M. J. Jones		DECEASED'S FATHER'S OCCUPATION None		DECEASED'S MOTHER'S OCCUPATION None		DECEASED'S FATHER'S PLACE OF BIRTH Baltimore, Md.		DECEASED'S MOTHER'S PLACE OF BIRTH Baltimore, Md.	
DECEASED'S FATHER'S DATE OF BIRTH 10-15-1910		DECEASED'S FATHER'S SEX Male		DECEASED'S FATHER'S RACE White		DECEASED'S FATHER'S AGE 45		DECEASED'S FATHER'S MANNER OF DEATH Natural		DECEASED'S FATHER'S CAUSE OF DEATH Heart Disease	
DECEASED'S MOTHER'S DATE OF BIRTH 10-15-1910		DECEASED'S MOTHER'S SEX Female		DECEASED'S MOTHER'S RACE White		DECEASED'S MOTHER'S AGE 45		DECEASED'S MOTHER'S MANNER OF DEATH Natural		DECEASED'S MOTHER'S CAUSE OF DEATH Heart Disease	
DECEASED'S FATHER'S PLACE OF DEATH Home		DECEASED'S MOTHER'S PLACE OF DEATH Home		DECEASED'S FATHER'S TIME OF DEATH 10:00 AM		DECEASED'S MOTHER'S TIME OF DEATH 10:00 AM		DECEASED'S FATHER'S DATE OF DEATH 10-25-1960		DECEASED'S MOTHER'S DATE OF DEATH 10-25-1960	
DECEASED'S FATHER'S NAME J. J. Jones		DECEASED'S MOTHER'S NAME M. J. Jones		DECEASED'S FATHER'S OCCUPATION None		DECEASED'S MOTHER'S OCCUPATION None		DECEASED'S FATHER'S PLACE OF BIRTH Baltimore, Md.		DECEASED'S MOTHER'S PLACE OF BIRTH Baltimore, Md.	
DECEASED'S FATHER'S DATE OF BIRTH 10-15-1910		DECEASED'S FATHER'S SEX Male		DECEASED'S FATHER'S RACE White		DECEASED'S FATHER'S AGE 45		DECEASED'S FATHER'S MANNER OF DEATH Natural		DECEASED'S FATHER'S CAUSE OF DEATH Heart Disease	
DECEASED'S MOTHER'S DATE OF BIRTH 10-15-1910		DECEASED'S MOTHER'S SEX Female		DECEASED'S MOTHER'S RACE White		DECEASED'S MOTHER'S AGE 45		DECEASED'S MOTHER'S MANNER OF DEATH Natural		DECEASED'S MOTHER'S CAUSE OF DEATH Heart Disease	
DECEASED'S FATHER'S PLACE OF DEATH Home		DECEASED'S MOTHER'S PLACE OF DEATH Home		DECEASED'S FATHER'S TIME OF DEATH 10:00 AM		DECEASED'S MOTHER'S TIME OF DEATH 10:00 AM		DECEASED'S FATHER'S DATE OF DEATH 10-25-1960		DECEASED'S MOTHER'S DATE OF DEATH 10-25-1960	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8056 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08029

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore CITY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Betterton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 2 Days		d. STREET ADDRESS 1419 N. Patterson Pk. Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Hotel		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruth Frances Curran		4. DATE OF DEATH July 7 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME James M. O'Neill		14. MOTHER'S MAIDEN NAME ELEANOR RUTH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? UNKNOWN (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-20-8915	
17. INFORMANT Eleanore Lomp		Address 907 Locustvale Rd. Balto.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) heart attack occurring while swimming DUE TO (b) prior heart disease, type unknown DUE TO (c) 4344 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) probable heart attack occurred in Chesapeake Bay, while swimming		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no gross evidence of injury. artificial resp. for 1 hr.	
20c. TIME OF INJURY Month, Day, Year 8 a.m. July 7 1959		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake Bay		20f. (City or town) Betterton (County) Kent (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> at 9:00 p.m. July 7, 1959			
ACTUAL SIGNATURE Florence Deringer Joyce		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED JULY 8, 1959	
EXAMINER'S NAME (Type) Florence Deringer Joyce		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/11/59	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran-3000 E. Baltimore Street		24a. REC'D BY REGISTRAR JUL 10 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Hunt	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASS LAND STATE DEPARTMENT OF HEALTH - BOSTON 18
6052 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

NAME

RESIDENCE

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE

MANNER

DATE OF BIRTH

SEX

EDUCATION

RELIGION

OCCUPATION

STATUS

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE

MANNER

DATE OF BIRTH

SEX

EDUCATION

RELIGION

OCCUPATION

STATUS

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE

MANNER

DATE OF BIRTH

SEX

8042

CERTIFICATE OF DEATH

Reg. Dist. No. 18030

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millington</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne Co. Hosp</u>			d. STREET ADDRESS <u>--</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Baker Girl</u> First Middle Last <u>Remby</u>			4. DATE OF DEATH Month <u>July</u> Day <u>11</u> , Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/11/59</u>	9. AGE (In years lost birthday) yrs. <u>55</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Chestertown, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Raymond Remby</u>		
14. MOTHER'S MAIDEN NAME <u>Carrie Hutchins</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		
16. SOCIAL SECURITY NO. <u>no</u>			17. INFORMANT <u>Hospital Records</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>---</u> DUE TO <u>---</u> (c) <u>---</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>7/11/59</u> , 19 <u>59</u> , to <u>7/11/59</u> , that I last saw the deceased alive on <u>7/11/59</u> , 19 <u>59</u> , and that death occurred at <u>3:40</u> A. M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>William M. Gatewood</u>			ADDRESS (Street, city or town, state) <u>M.D. Chestertown, Md.</u> DATE SIGNED <u>7/11/59</u>		
PHYSICIAN'S NAME (Type) <u>William M. Gatewood</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/12/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Janes Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Walby</u>			ADDRESS <u>Chestertown, Md.</u>		
24a. REC'D BY REGISTRAR DATE <u>JUL 15 '59</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2072285XV0

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G246 8-17-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

08031

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ----		4. STREET ADDRESS ---	
3. NAME OF DECEASED (Type or print) Otto First Frederick Gessner Last		4. DATE OF DEATH Month July Day 26 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 11, 1893
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Advertising		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Gessner		14. MOTHER'S MAIDEN NAME Lizzie Will	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 159-03-8933	
17. INFORMANT Mrs. John Chaires--Rock Hall, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis DUE TO (c) Arterio Sclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1, 1959 to July 26, 1959 , that I last saw the deceased alive on July 26, 1959 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Norbert C. Nitsch M.D.		ADDRESS (Street, city or town, state) Rock Hall Md.	
PHYSICIAN'S NAME (Type) NORBERT C. NITSCH		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF July 30-59	22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel	22d. LOCATION (City, town, or county) (State) Rock Hall Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		ADDRESS Church Hill	
24a. REC'D BY REGISTRAR AUG 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		MARYLAND BALTIMORE	
DATE OF DEATH JAN 10 1951		TIME OF DEATH 10:00 AM	
SEX FEMALE		AGE 78	
RACE WHITE		OCCUPATION HOUSEWIFE	
MARITAL STATUS MARRIED		PLACE OF BIRTH BALTIMORE, MARYLAND	
NAME OF DECEASED MRS. J. M. SMITH		NAME OF NEXT OF KIN J. M. SMITH	
ADDRESS 1234 E. BALTIMORE AVE. BALTIMORE, MARYLAND		CAUSE OF DEATH HEART DISEASE	
DATE OF BIRTH JAN 10 1873		PLACE OF BIRTH BALTIMORE, MARYLAND	
SEX FEMALE		AGE 78	
RACE WHITE		OCCUPATION HOUSEWIFE	
MARITAL STATUS MARRIED		PLACE OF BIRTH BALTIMORE, MARYLAND	
NAME OF DECEASED MRS. J. M. SMITH		NAME OF NEXT OF KIN J. M. SMITH	
ADDRESS 1234 E. BALTIMORE AVE. BALTIMORE, MARYLAND		CAUSE OF DEATH HEART DISEASE	



RECEIVED
 JAN 10 1951
 BALTIMORE, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8043

CERTIFICATE OF DEATH

Reg. Dist. No.

18032

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chestertown, Md. Rock Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Annes Hosp</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>Boy</u> Last <u>GOLDSBORO</u>		4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/6/59</u>
9. AGE (In years lost birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George ALBERT GOLDSBORO</u>		14. MOTHER'S MAIDEN NAME <u>Alice Elizabeth Harris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mother</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Foetal asphyxia</u> <u>762.5</u> DUE TO <u>prematurity (1lb 14oz)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>prematurity (1lb 14oz)</u> DUE TO (c) <u>prematurity (1lb 14oz)</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-6</u> , 19 <u>59</u> , to <u>7-8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-8</u> , 19 <u>59</u> , and that death occurred at <u>1:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry Paul Ross</u> M.D.		ADDRESS (Street, city or town, state) <u>203 N Queen ST</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>HARRY PAUL ROSS</u>		<u>Chestertown, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 9, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Broad Neck</u>	22d. LOCATION (City, town, or county) (State) <u>near Chestertown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Walker</u>		ADDRESS <u>Chestertown, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>JUL 10 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaul</u>	

2072214XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No. 08033

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN b 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS Kent Street	
3. NAME OF DECEASED (Type or print) Elizabeth Agnes Gorsuch		4. DATE OF DEATH Month July Day 17 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1891
9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Ritmiller		14. MOTHER'S MAIDEN NAME Agusta Cooney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-20-1190	
17. INFORMANT Charles W. Gorsuch, Chestertown, Md. (son)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 hours ? 7 years 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-31- 1957 , to 7-17 1959 , that I last saw the deceased alive on 7-1 1959 , and that death occurred at 3:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Maryland DATE SIGNED 7-17-59			
ACTUAL SIGNATURE A.C. Dick M.D.		PHYSICIAN'S NAME (Type) A.C. Dick	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/19/59	
22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. H. Mills		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE JUL 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8058

CERTIFICATE OF DEATH

Reg. Dist. No.

08034

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Chestertown		c. LENGTH OF STAY IN lb life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION near Fairlee		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Albert First B. Middle Groves Last		4. DATE OF DEATH July 25, 1959 Month July Day 25 Year 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1886
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR: Months 72 Days 72 Hours 72 Min. 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Tenant	
11. BIRTHPLACE (State or foreign country) Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? Usa	
13. FATHER'S NAME James H. Groves		14. MOTHER'S MAIDEN NAME Sarah Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-38-1107	
17. INFORMANT Mrs. Albert B. Groves - Chestertown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Vascular DUE TO (c) Aortic Sclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 51 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 19 59 , to July 25 , 19 59 , that I last saw the deceased alive on July 25 , 19 59 , and that death occurred at 3:45 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Norbert C. Nitsch M.D.		DATE SIGNED 7/25/59	
PHYSICIAN'S NAME (Type) Norbert C. Nitsch		2k Rock Hall, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 28, 1959	
22c. NAME OF CEMETERY OR CREMATORY St. Paul Cem.		22d. LOCATION (City, town, or county) (State) near Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wilks Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR JUL 28 '59		24b. REGISTRAR'S SIGNATURE Carlton L. Harris	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8045

CERTIFICATE OF DEATH

Reg. Dist. No. 18035

1. PLACE OF DEATH a. COUNTY <u>Stent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesertown</u>				c. LENGTH OF STAY IN 1b <u>17X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne Co. Hosp</u>				d. STREET ADDRESS <u>Crumpton</u>			
3. NAME OF DECEASED (Type or print) First <u>Susan</u> Middle <u>Maria</u> Last <u>Hudson</u>				4. DATE OF DEATH Month <u>7</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/25/1883</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>James Walls</u>			
14. MOTHER'S MAIDEN NAME <u>Lottie Bodwin</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>180</u>				17. INFORMANT <u>Daughters</u> Address <u>Crumpton, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute posterior Myocardial Damage</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>59</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>7/4</u> , 19 <u>59</u> , to <u>7/12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/6</u> , 19 <u>59</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Gatewood</u> M.D.				ADDRESS (Street, city or town, state) <u>Chesertown, Md</u> DATE SIGNED <u>7/12/59</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM GATEWOOD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CRUMPTON</u>		22d. LOCATION (City, town, or county) (State) <u>GREEN ANNE'S Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar S. LANE</u> Address <u>Chesertown, Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital pending physician's action.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove page 1 and 2 from the papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8046

CERTIFICATE OF DEATH

08036

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY KENT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 CHESTERTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) KENT & QUEEN ANNE'S				d. STREET ADDRESS 1415 CALVERT ST.			
3. NAME OF DECEASED (Type or print) First MARY Middle ETHEL Last JOHNSON				4. DATE OF DEATH Month JUL Day 11 Year 1959			
5. SEX F	6. COLOR OR RACE COL	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/25/1881	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.5 INTESTINAL OBSTRUCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUL 11, 1959 , to JUL 11, 1959 , that I last saw the deceased alive on JUL 11, 1959 , and that death occurred at 5:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) CHESTERTOWN, Md DATE SIGNED 7-11-59							
ACTUAL SIGNATURE A.T. KEEFE				M.D. A.T. KEEFE, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/15/59		22c. NAME OF CEMETERY OR CREMATORY Georgetown Cem.		22d. LOCATION (City, town, or county) (State) near Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Colby				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE JUL 15 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital and the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2040

PLACE OF DEATH HOME		DATE OF DEATH 10-10-1917	
SEX FEMALE		AGE 65	
RACE WHITE		OCCUPATION HOUSEWIFE	
MARITAL STATUS MARRIED		PLACE OF BIRTH BALTIMORE, MARYLAND	
NAME OF DECEASED MARY ANN BROWN		NAME OF FATHER JOHN BROWN	
NAME OF MOTHER SARAH BROWN		NAME OF SPOUSE WILLIAM BROWN	
CAUSE OF DEATH HEART DISEASE		PLACE OF INTERMENT GREENWICH CEMETERY	
TIME OF DEATH 10:30 AM		SIGNATURE OF PHYSICIAN J. H. BROWN	
SIGNATURE OF REGISTRAR J. H. BROWN		SIGNATURE OF WITNESS J. H. BROWN	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR ANY OTHER PURPOSES. IT IS NOT VALID FOR ANY OTHER PURPOSES. IT IS NOT VALID FOR ANY OTHER PURPOSES.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8059

CERTIFICATE OF DEATH

Reg. Dist. No.

08037

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lynch</u>		c. LENGTH OF STAY IN 1b <u>12 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Lynch</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lynch, Md</u>				d. STREET ADDRESS <u>Lynch</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Edward</u> Last <u>Merch</u>				4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11, 1889</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Kent Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Edward Merch</u>				14. MOTHER'S MAIDEN NAME <u>Katie Linda Gaiser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>207 101538</u>		17. INFORMANT Name <u>Mrs. Howard E Merch</u> Address <u>Lynch, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis generalized</u> DUE TO (c) <u>6 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>1959</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>54</u> , to <u>JULY 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JULY 14</u> , 19 <u>59</u> , and that death occurred at <u>2:15</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.C. Dick</u> M.D.				ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>7-14-59</u>			
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>STILL POND CEMT</u>		22d. LOCATION (City, town, or county) (State) <u>STILL POND, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u> ADDRESS <u>STILL POND, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		M		45		W		10/15/1890		BALTIMORE, MD		10/20/1935		BALTIMORE, MD		HEART DISEASE		NATURAL		J. H. HARRIS		J. H. HARRIS	
13. FULL NAME OF PHYSICIAN		14. FULL NAME OF REGISTRAR		15. FULL NAME OF WITNESS		16. FULL NAME OF WITNESS		17. FULL NAME OF WITNESS		18. FULL NAME OF WITNESS		19. FULL NAME OF WITNESS		20. FULL NAME OF WITNESS		21. FULL NAME OF WITNESS		22. FULL NAME OF WITNESS		23. FULL NAME OF WITNESS		24. FULL NAME OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
13. FULL NAME OF PHYSICIAN		14. FULL NAME OF REGISTRAR		15. FULL NAME OF WITNESS		16. FULL NAME OF WITNESS		17. FULL NAME OF WITNESS		18. FULL NAME OF WITNESS		19. FULL NAME OF WITNESS		20. FULL NAME OF WITNESS		21. FULL NAME OF WITNESS		22. FULL NAME OF WITNESS		23. FULL NAME OF WITNESS		24. FULL NAME OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

1

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD, AND IN THE OFFICE OF THE REGISTRAR OF DEATHS, COUNTY OF BALTIMORE, MD.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8060

CERTIFICATE OF DEATH

Reg. Dist. No.

08038

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Nadolny Last Nadolny				4. DATE OF DEATH Month July Day 17 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1894		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min.	IF UNDER 24 HRS. Months 65 Days 65 Hours 65 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maternal		10b. KIND OF BUSINESS OR INDUSTRY Ashley Packing Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wojciech Nadolny				14. MOTHER'S MAIDEN NAME Mary Borjas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-07-1101		17. INFORMANT Stanislaus Nadolny Address 614 South Washington Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Hypertension Cordis Vasculosa Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis (c) Atherosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 19 59 , to July 17, 19 59 , that I last saw the deceased alive on July 17, 19 59 , and that death occurred at 11 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Norbert Nitsch M.D.				ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED 7/17/59			
PHYSICIAN'S NAME (Type) Norbert Nitsch							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 21, 1959		22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George A. Weber ADDRESS 705 S. Ann St; Balt.				24a. REC'D BY REGISTRAR DATE 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

8047

CERTIFICATE OF DEATH

08039

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary E Nicholson				4. DATE OF DEATH Month Day Year July 5 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 30, 1884	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert G. Nicholson				14. MOTHER'S MAIDEN NAME Laura Lusby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Hospital Records, Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Bronchopneumonia DUE TO (b) Bed Confinement Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Spontaneous subarachmoid hemorrhage INTERVAL BETWEEN ONSET AND DEATH 6 days 12 days 12 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from June 24 , 19 59 , to July 5 , 19 59 , that I last saw the deceased alive on July 5 , 19 59 , and that death occurred at 8:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 7/5/59							
ACTUAL SIGNATURE R. W. Farr		M.D. Chestertown, Md.					
PHYSICIAN'S NAME (Type) Robert W. Farr							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 7, 1959	22c. NAME OF CEMETERY OR CREMATORY Chester Cem.	22d. LOCATION (City, town, or county) (State) Chestertown, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE JUL 7 '59	24b. REGISTRAR'S SIGNATURE Criner S. Hume		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8061 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3 FilmG246 7-31-59 et

Reg. Dist. No.

08040

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Pennsylvania COUNTY Kent York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton Creek Marina		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) York RFD 75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA * Kent & Queen Anne Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Virginia Middle Carolyn Peterson Last		4. DATE OF DEATH Month July Day 25 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Penna
13. FATHER'S NAME Robert Peterson		14. MOTHER'S MAIDEN NAME Alice Uzle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Max Anstine York, Penna		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 850X ASPHIXIATION DUE TO (b) DROWNING Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL OFF A BOAT			INTERVAL BETWEEN ONSET AND DEATH 20 min.
20c. TIME OF INJURY Hour 6 p. m. Month, Day, Year JUL 25 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) BOAT
20f. (City or town) WORTON		(County) KENT (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Arthur T. Keefe		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 28, 1959	22c. NAME OF CEMETERY OR CREMATORY Mt. Rose Cem.
22d. LOCATION (City, town, or county) York		(State) Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE JUL 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

8048

CERTIFICATE OF DEATH

08041

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY KENT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X KENNEDYVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT & QUEEN ANNE'S Hosp				e. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First TERRY Middle LEE Last REESE				4. DATE OF DEATH Month JULY Day 14 Year 1959			
5. SEX F	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 12, 1959		9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES BURTON REESE				14. MOTHER'S MAIDEN NAME MARGARET ELIZABETH MONEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address HOSPITAL RECORDS CHESTERTOWN, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus + severe + extensive 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) spinal bifida - DUE TO (c) 20 days in							INTERVAL BETWEEN ONSET AND DEATH 20 days in
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 1959 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/12 , 19 59 , to 7-14 , 19 59 , that I last saw the deceased alive on 7-14 , 19 59 , and that death occurred at 12:00 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md DATE SIGNED 7/14/59							
ACTUAL SIGNATURE R. R. W. Farr		M.D. Chestertown, Md					
PHYSICIAN'S NAME (Type) ROBERT W. FARR							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-16-59		22c. NAME OF CEMETERY OR CREMATORY CHESTER CEMETERY		22d. LOCATION (City, town, or county) (State) CHESTERTOWN, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Victor M. Kennedy				ADDRESS STILL POND, MD		24a. REC'D BY REGISTRAR DATE JUL 16 59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Thoms			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2072201XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8062 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

08042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCK HALL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCK HALL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORNELIA</u> <u>RODNEY</u>		4. DATE OF DEATH Month Day Year <u>JULY</u> <u>16</u> <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 13 = 1889</u>
9. AGE (In years lost birthday) yrs. <u>70</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>70</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM CRAIGHTON</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE COLEMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Mr Thomas C. Rodney Rock Hall</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio Vascular, Hypertension</u> (c) <u>Vascular Lesion (arteriosclerotic changes)</u> 5 1/2" Craniol		INTERVAL BETWEEN ONSET AND DEATH <u>7</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 15</u> , 19 <u>59</u> , to <u>July 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 16</u> , 19 <u>59</u> , and that death occurred at <u>10:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert C. Nitsch</u>		ADDRESS (Street, city or town, state) <u>Rock Hall</u>	
PHYSICIAN'S NAME (Type) <u>NORBERT NITSCH</u>		DATE SIGNED <u>7/17/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 19</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WESLEY CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>ROCK HALL MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 23 '59</u>	
ADDRESS <u>Church Hill Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Christina S. Kras</u>	

8049

CERTIFICATE OF DEATH

08043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. LENGTH OF STAY IN 1b <u>entire life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EMERG ROOM Kent Queen Anne's</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kennedyville</u>			
f. STREET ADDRESS <u>1</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>ANN</u> Last <u>ROY</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 28, 1958</u>	
9. AGE (In years last birthday) yrs. <u>6</u>		IF UNDER 1 YEAR Months <u>21</u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>FRED (N) ROY</u>				14. MOTHER'S MAIDEN NAME <u>MARY MARJORIE WILSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>FRED ROY Kennedyville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <u>NATURAL—PROBABLY DUE TO</u> INTERVAL BETWEEN ONSET AND DEATH <u>57 1/2</u>							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>OVERWHELMING INFECTION—WITH Dehydration DUE TO VOMITING & DIARRHEA—</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last: (b) <u>HAD BEEN SEEN BY ANOTHER M.D. JUL 16, 17, & 18—</u>							
(c) <u>17, & 18—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>19 July, 1959</u> , to <u>19 July, 1959</u> , that I last saw the deceased alive on <u>Never</u> <u>19</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry Paul Ross</u> M.D. <u>203 N. Queen ST</u> ADDRESS (Street, city or town, state)				DATE SIGNED <u>7/19/59</u>			
PHYSICIAN'S NAME (Type) <u>HARRY PAUL ROSS</u> <u>Chestertown, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>7-21-59</u>		<u>MT. ZION CEMTY</u>		<u>STILL POND MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor M. Kennedy</u> ADDRESS <u>STILL POND MD</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital for pending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2072253XV4

CERTIFICATE OF DEATH

MD 900-100

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>10/15/1968</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. ICD-9 CODE <i>410.91</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. SIGNATURE OF DECEASED <i>John J. Brown</i>		12. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
13. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		14. SIGNATURE OF DECEASED <i>John J. Brown</i>		15. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
16. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		17. SIGNATURE OF DECEASED <i>John J. Brown</i>		18. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
19. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		20. SIGNATURE OF DECEASED <i>John J. Brown</i>		21. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
22. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		23. SIGNATURE OF DECEASED <i>John J. Brown</i>		24. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
25. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		26. SIGNATURE OF DECEASED <i>John J. Brown</i>		27. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
28. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		29. SIGNATURE OF DECEASED <i>John J. Brown</i>		30. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
31. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		32. SIGNATURE OF DECEASED <i>John J. Brown</i>		33. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
34. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		35. SIGNATURE OF DECEASED <i>John J. Brown</i>		36. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
37. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		38. SIGNATURE OF DECEASED <i>John J. Brown</i>		39. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
40. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		41. SIGNATURE OF DECEASED <i>John J. Brown</i>		42. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
43. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		44. SIGNATURE OF DECEASED <i>John J. Brown</i>		45. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
46. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		47. SIGNATURE OF DECEASED <i>John J. Brown</i>		48. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
49. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		50. SIGNATURE OF DECEASED <i>John J. Brown</i>		51. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
52. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		53. SIGNATURE OF DECEASED <i>John J. Brown</i>		54. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
55. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		56. SIGNATURE OF DECEASED <i>John J. Brown</i>		57. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
58. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		59. SIGNATURE OF DECEASED <i>John J. Brown</i>		60. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
61. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		62. SIGNATURE OF DECEASED <i>John J. Brown</i>		63. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
64. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		65. SIGNATURE OF DECEASED <i>John J. Brown</i>		66. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
67. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		68. SIGNATURE OF DECEASED <i>John J. Brown</i>		69. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
70. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		71. SIGNATURE OF DECEASED <i>John J. Brown</i>		72. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
73. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		74. SIGNATURE OF DECEASED <i>John J. Brown</i>		75. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
76. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		77. SIGNATURE OF DECEASED <i>John J. Brown</i>		78. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
79. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		80. SIGNATURE OF DECEASED <i>John J. Brown</i>		81. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
82. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		83. SIGNATURE OF DECEASED <i>John J. Brown</i>		84. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
85. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		86. SIGNATURE OF DECEASED <i>John J. Brown</i>		87. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
88. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		89. SIGNATURE OF DECEASED <i>John J. Brown</i>		90. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
91. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		92. SIGNATURE OF DECEASED <i>John J. Brown</i>		93. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
94. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		95. SIGNATURE OF DECEASED <i>John J. Brown</i>		96. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
97. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		98. SIGNATURE OF DECEASED <i>John J. Brown</i>		99. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	
100. SIGNATURE OF REGISTRAR <i>John J. Brown</i>		101. SIGNATURE OF DECEASED <i>John J. Brown</i>		102. SIGNATURE OF WITNESSES <i>Dr. J. H. Smith, Dr. M. K. Jones</i>	

1

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD, AND A COPY IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDES.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8050

CERTIFICATE OF DEATH

Reg. Dist. No.

08044

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hosp.				d. STREET ADDRESS Sharp St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANN Middle SHIRK Last				4. DATE OF DEATH Month July Day 29 Year 19 59			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15 1885		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeping		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Middletown Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Franklin Ober				14. MOTHER'S MAIDEN NAME Emma Nissley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 203-07-0654A		17. INFORMANT Mr. P. O. Shirk		Address Rock Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Sept 19 58 to July 19 59 , that I last saw the deceased alive on July 29 59 , and that death occurred at 5:30 PM , from the causes and on the date stated above. ADDRESS (street, city or town, state) DATE SIGNED Willie M. Williams M.D. 7/30/59							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 1 1959		22c. NAME OF CEMETERY OR CREMATORY Mt. Tunnel Cemetery		22d. LOCATION (City, town, or county) (State) Elizabethtown Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE JUL 31 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director, may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8051

CERTIFICATE OF DEATH

Reg. Dist. No.

08045

1. PLACE OF DEATH o. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>				c. LENGTH OF STAY IN 1b <u>45 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT & QUEEN ANNE HOSP</u>				d. STREET ADDRESS <u>Rock Hall</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Tucker</u>				4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-59</u>	9. AGE (In years lost birthday) <u>N.B.</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>			11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Franklin Burgess Tucker</u>				14. MOTHER'S MAIDEN NAME <u>Betty Kimbler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>MOTHER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inmaturity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>776x</u> DUE TO (c) <u>776x</u> DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>7/25/59</u> 19 <u>59</u> to <u>7/25/59</u> 19 <u>59</u> , that I last saw the deceased alive on <u>7/25/59</u> 19 <u>59</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William M. Galloway</u>				M.D. <u>Rock Hall</u>		DATE SIGNED <u>7/25/59</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall</u> <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane Church Hill</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUL 30 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Thoma</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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